

# Administrative Information



This section contains information on the administration and funding of all the plans described in this handbook, as well as your rights as a plan participant. While you may not need this information for day-to-day participation in your benefit plans, you should read through this section. It is important for you to understand your rights, the procedures you need to follow, and the appropriate contacts you may need in certain situations.

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# Plan Sponsor and Administrator

BWXT Y-12, LLC is the sponsor and the designated plan administrator of the multiple employer plans described in this handbook. BWXT Y-12, LLC and UT-Battelle, LLC are the sponsors of their separate single employer plans as listed in this handbook.

## **BWXT Y-12, LLC**

c/o Manager, Benefits Management  
P.O. Box 2009  
Oak Ridge, TN 37831-8267  
(865) 574-9110

## **UT-Battelle, LLC**

c/o Plan Administrator, Employee Benefits  
P.O. Box 2008  
Oak Ridge, TN 37831-6480  
(865) 576-8844

In carrying out its responsibilities under the plans, the plan administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the plans, including but not limited to, the power to interpret the terms of the plans, to determine eligibility for entitlement to plan benefits, and to resolve all interpretive, equitable, and other questions that arise in the operation and administration of the plans. All actions or determinations of the plan administrator are final, conclusive, and binding on all persons.

# Employer Identification Number

The employer identification number assigned by the Internal Revenue Service to BWXT Y-12, LLC is 54-1987297.

The employer identification number assigned to UT-Battelle, LLC is 62-1788235.



# Plan Documents

This handbook summarizes the key features of each of the plans in the Company's benefits program and applies to eligible retirees of the Company, including those represented by collective bargaining units to the extent that they have been negotiated and accepted by the duly certified representatives of participating units.

Complete details of each of the plans can be found in the official plan documents, insurance contracts, and trust agreements (as applicable) that legally govern the operation of the plans. All statements made in this handbook are subject to the provisions and terms of those documents. Copies of those documents, as well as the latest annual reports of plan operations and plan descriptions as filed with the Internal

Revenue Service and the U.S. Department of Labor, are available for your review any time during normal working hours in the office of the plan administrator.

Upon written request to the plan administrator, at the address previously mentioned, copies of any of these documents will be furnished to a plan participant or beneficiary, generally within 30 days, at a nominal charge. In addition, once each year you will receive a copy of the summary annual reports of the plans' financial activities at no charge.

In the event of a conflict between the official plan documents and the summaries in this handbook, the plan documents are controlling.

## Claiming Benefits

You or your beneficiary must file the appropriate forms to receive any benefits, or to take any other action under any of the plans, as described throughout this handbook.

All forms required to take any action under the plans are available through the Benefit Plans Office. All completed forms must be submitted to the appropriate office, as described throughout this handbook.



# Claims Review & Appeal Procedures

You may file claims for plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf with respect to a claim or appeal for benefits. The plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of a medical claim involving urgent care, a health care professional with knowledge of your condition may act as your authorized representative, unless you have designated a different authorized representative. References to you in this section are intended to include references to your authorized representative.

If your claim for benefits is denied, you cannot bring a lawsuit to recover benefits under the plan unless you have timely exercised all appeal rights available to you under the plan's administrative claims procedures for a denied claim and your appeal(s) seeking benefits have been denied by the plan.

## Urgent Health Care Claims

If the plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the plan or your physician determines that it is an Urgent Care Claim, you will be notified of the decision as soon as possible, but not later than 72 hours after the claim is received unless you fail to provide sufficient information for the plan to make a decision.

"Urgent Care" means services received for a sudden illness, injury or condition that is not an emergency condition, but requires immediate outpatient medical care that cannot be postponed. An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of a person's health or ability to regain maximum function; this includes a condition that, in the opinion of a physician with knowledge of your medical condition, would subject a person to severe pain that could not be adequately managed without prompt treatment. The determination of whether a claim is an Urgent Care Claim will be made by an individual acting on behalf of the plan applying the judgment of a prudent lay person who possesses an average knowledge of health and medicine or by a physician with knowledge of your medical condition who determines the claim involves urgent care.

If there is not sufficient information to decide the claim, you will be notified of the specific information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision as soon as possible, but not later than 48 hours after the end of that additional time period (or after receipt of the specified information, if earlier).

## Other Health Claims (Pre-Service and Post-Service)

If the plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision as soon as possible, but not later than 15 days after receipt of the pre-service claim.

# Claims Review & Appeal Procedures (cont'd.)

For other claims (post-service claims), you will be notified of the decision as soon as possible, but not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period.

For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a plan representative responsible for handling benefit matters, but which otherwise fail to follow the plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

## Ongoing Course of Health Treatment

If you are receiving an ongoing course of treatment, you will be notified in advance if the plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, you must request an extension of the course of treatment at least 24 hours before its expiration. You will be notified of the decision within 24 hours after receipt of the request.

## Notification of Health Claim Decision

If a claim for plan benefits is denied in whole or in part, you will receive written or electronic notification that will include:

- 1) the specific reasons for the denial with reference to the specific plan provisions on which the denial was based,
- 2) a description of any additional information needed to complete the claim and an explanation of why such information is necessary,
- 3) a description of the plan's claim review procedures and applicable time limits, and
- 4) a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided to you free of charge upon request.

If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit when applying the terms of the plan to the participant's medical circumstances, an explanation of the scientific or clinical judgment for the denial will be provided, or the denial will state that such an explanation is available upon request at no cost to you.

In the case of an Urgent Care Claim, the above information may be provided orally within the timeframes described in the Urgent Care Claims section, provided that a written or electronic notification as described is furnished to you no later than 3 days after the oral notification.



# Claims Review & Appeal Procedures (cont'd.)

## Information Pertaining to the Filing of an Appeal of an Adverse Benefit Determination for a Health Claim

With the exception of Urgent Care Claims, you will have 180 days following receipt of an adverse benefit decision to appeal the decision. If you fail to appeal within this period of time, you may not seek a reconsideration of your claim. You will be notified of the decision no later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. The appeal will take into account all documents, records and other information that you submit or that are submitted on your behalf regarding the claim, without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision to deny the claim and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the initial denial, nor the subordinate of such individual.

For claim appeals, the Claim Administrator has been delegated exclusive rights to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding. The appeal may, but does not have to be, submitted in writing. An expedited appeal may be initiated by a telephone call to Member Services. You or your authorized representative may appeal the claim. All necessary information, including the appeal decision, will be communicated to you or your authorized representative by telephone, facsimile, or other similar method. You will be notified of the decision no later than 72 hours after the appeal is received.

In reconsidering any denial that is based in whole or in part on a medical judgment, (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate) the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the individual that was consulted in connection with the initial denial of the claim nor a subordinate of any such individual. If the plan obtains other medical or vocational experts in connection with your claim, they will be identified upon your request, regardless of whether the plan relies on their advice in making any benefit determinations.

# Claims Review & Appeal Procedures (cont'd.)

## Notification of Health Claim Decision on Appeal

If your appeal seeking reconsideration of the denied claim under the plan is again denied in whole or in part, you will receive written or electronic notification that will include:

- 1) the reasons for the decision, again with reference to the specific plan provisions on which that decision is based,
- 2) that you are entitled to receive, upon request and free of charge, reasonable access to and copies of pertinent documents, records, and other information relevant to your claim for benefits, and
- 3) your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either a copy of or statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the determination will be provided free of charge to you upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to your medical circumstances, or a statement that such an explanation is available will be provided to you free of charge upon request.

The plan's claims review procedures do not generally include any voluntary levels of appeal (such as voluntary arbitration).

Finally, you and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.



# Legal Process

Any legal process relating to a benefit plan should be directed to the plan's Agent for Service of Legal Process.

Legal process may also be served upon the plan trustee (where applicable) or the plan administrator.

## Agent for Service of Legal Process

BWTX Y-12, LLC  
Corporation Service  
Company  
2908 Poston Avenue  
Nashville, TN 37203

UT-Battelle, LLC  
Steven L. Porter  
General Counsel  
One Bethel Valley Road  
Oak Ridge, TN 37831-6265

# Plan Termination and Amendment

The Company expects and intends to continue the plans in your benefits program but reserves its right to terminate each of the plans, in whole or in part, without notice. The Company also reserves its right to amend each of the plans at any time.

The Company may also increase or decrease its contributions or the participants' contributions to the plans.

The Company's decision to terminate or amend a plan may be due to changes in federal or state laws governing pension or welfare benefits, the requirements of the Internal Revenue Code or ERISA, or any other reason. A plan change may result in the transfer of plan assets and debts to another plan or split a plan into two or more parts. If the Company does terminate or amend a plan, it may decide to set up a different plan providing similar or identical benefits, but it is under no obligation to do so.

If the pension plan or savings program is terminated, you will have a vested right to the value of your accrued retirement benefit under the pension plan or the entire value of your savings account, as applicable. Once your pension plan benefit or savings program account value has been determined, it may be paid in the form of one or more cash payments. The exact form of payment may be set by law; if there is a choice, the plan administrator will decide the type and timing of payment.

If a welfare plan is terminated, you will not have any further rights, other than the payment of benefits for covered losses or expenses incurred before the plan was terminated, and for covered medical plan expenses related to a total disability existing before the plan was terminated, which are incurred within three months after termination of the plan. The amount and form of any final benefit you or your beneficiary receives will depend on any insurance contract provisions affecting the plan and the Company's decisions.

# Special Pension and Savings Provisions

There are a few special provisions that apply only to the savings program and pension plan.

## Assets Upon Termination

If the savings program terminates, participants' accounts will be distributed after plan expenses are paid. The trustee will make account distributions as instructed by the plan administrator.

Any assets remaining in the pension plan after all liabilities to participants and beneficiaries are satisfied, and after all expenses are paid, will revert to the Company.

## Pension Benefit Guaranty Corporation

Your pension benefits under the pension plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates
- some or all of benefit increases and new benefits based plan provisions that have been in place for fewer than 5 years at the time the plan terminates
- benefits that are not vested because you have not worked long enough for the Company
- benefits for which you have not met all of the requirements at the time the plan terminates
- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age  
*and*
- non-pension benefits such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has, and on how much the PBGC collects from retirees.

For more information about the PBGC and the benefits it guarantees, ask the plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Washington, D.C. 20005-4026, or call 202-926-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at <http://www.pbgc.gov>.



# Special Pension and Savings Provisions (cont'd.)

## Assignment or Alienation of Benefits

Except as required by applicable law (such as a qualified domestic relations order), benefits provided under the pension plan and savings program are not subject to assignment, alienation, attachment, lien, garnishment, levy, pledge, bankruptcy, execution, or any other form of transfer.

In the event of a QDRO, benefits under the pension plan and savings program may be payable to someone other than your designated beneficiary to satisfy a legal obligation you may have to a spouse, former spouse, child or other dependent. Your pension plan or savings program benefits will be reduced by the benefits payable under the QDRO to someone else.

## Qualified Domestic Relations Order

A qualified domestic relations order (QDRO) is a legal judgment, decree, or order that recognizes the rights of another individual under the savings program or pension plan with respect to child or other dependent support, alimony or marital property rights.

There are specific requirements which a domestic relations order must meet to be recognized by the Company as a QDRO, and specific procedures regarding the amount and timing of payments. If you are affected by such an order, you will be notified by the Benefit Plans Office. Participants and beneficiaries may obtain, without charge, a copy of the plan's procedures governing QDROs from the plan administrator.

# Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is an order or judgment from a state court directing the plan administrator to cover a child for benefits under the health care plans. Coverage will be provided according to a valid order that is served on the Company or the Company's agent for service of legal process.

If you are affected by such an order, you and each child will be notified about further procedures to validate and implement the order. Participants and beneficiaries may obtain, without charge, a copy of the plan's procedures for determining the validity of a QMCSO and administering a QMCSO from the plan administrator.

## Health Insurance Portability and Accountability Act (HIPAA)

This plan operates in accordance with regulations under the Health Insurance Portability and Accountability Act ("HIPAA") with respect to protected health information ("PHI"). For purposes of the plan, PHI generally consists of individually identifiable information

about you or your dependents, including health and demographic information, that relates to your or their eligibility for all group health benefits under the plan. Additional information about your rights under HIPAA are provided separately in a Notice of Privacy Practices.



# Other Administrative Facts

## Multiple Employer Plans, Participating Employers BWXT Y-12, LLC and UT-Battelle, LLC

Plan Name	Plan Number	Plan Type	Plan Year
Retirement Program Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	001	Defined Benefit	Calendar
Savings Program for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee	009	Defined Contribution and 401(k) Plan	Calendar

**The Group Welfare Benefit Plan for Employees of Certain Employers of the U.S. Department of Energy Facilities at Oak Ridge, Tennessee. This newly combined plan provides for the following benefits previously provided by separate plans:**

Plan Name	Plan Number	Plan Type	Plan Year
Group Life Insurance	506	Welfare	Calendar
Health Benefits (Medical, Dental, Vision)	506	Welfare	Calendar

## Other Administrative Facts (cont'd.)

Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Northern Trust Company serves as Trustee  The Northern Trust Company 50 South LaSalle Street Chicago, IL 60675	Company	Benefits are funded through group annuity contracts and assets in separate investment accounts, all of which are held in one trust
State Street Bank and Trust serves as Trustee  State Street Bank and Trust P.O. Box 1389 Boston, MA 02104-1389	Employee and Company	Benefits are paid by the Plan Trustee from assets held in the trust
Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Metropolitan Life Insurance Company	Employee and Company	Benefits are paid from an insurance contract
Connecticut General Insurance Company - Medical MetLife - Dental Vision Service Plan - Vision Care	Employee and Company	Benefits are paid from an insurance contract



## Other Administrative Facts (cont'd.)

### Single Employer Plans BWXT Y-12, LLC

Plan Name	Plan Number	Plan Type	Plan Year
Prescription Drug Plan	515	Welfare	Calendar

### Single Employer Plans UT-Battelle, LLC

Plan Name	Plan Number	Plan Type	Plan Year
Prescription Drug Plan	501	Welfare	Calendar

## Other Administrative Facts (cont'd.)

Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Merck-Medco	Employee and Company	Benefits are paid (through claims administrator, Merck-Medco) from employee contributions and general assets of the Company

Insurer, Claims Administrator, or Trustee	Source of Contributions	Source of Benefits
Merck-Medco	Employee and Company	Benefits are paid (through claims administrator, Merck-Medco) from employee contributions and general assets of the Company



# Your Rights Under COBRA

You and your dependents covered under the group health (including dental plan), have the option to purchase a temporary continuation of health care coverages at full group rates, plus a 2% administrative charge in certain instances when your coverage would otherwise end. This is called COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

Continued coverage is available for a maximum of 18, 29, or 36 months, depending on the circumstances outlined in the chart below. The maximum continuation period, if multiple circumstances should occur, is a total of 36 months. For example, if you terminate employment and then die, your dependents' coverage may continue for 36 months from your termination date.

## COBRA Participation

If one of the circumstances listed in the chart below causes you or a dependent to lose health care coverage, you may continue your medical (including prescription drug and vision care) and dental coverage for you and your eligible dependents. If you adopt or have a child while covered by COBRA, that child is also a qualified beneficiary entitled to COBRA coverage.

COBRA Continuation Period		
Circumstances	Maximum Continuation Period	
	Spouse	Child
You die	36 months*	36 months*
You and your spouse legally separate or divorce	36 months	36 months
You become entitled to Medicare	36 months	36 months
Your child no longer qualifies as a dependent	n/a	36 months
<i>* If your dependent is eligible for extended coverage under the medical plan, as described in the Medical Section, then the maximum COBRA period will be reduced by the length of that extended coverage.</i>		

# Your Rights Under COBRA (cont'd.)

## Choosing COBRA

Here are some things to keep in mind about COBRA continuation:

You and your eligible dependents have 60 days after your COBRA notice to elect continued participation. You will have an additional 45-day period to pay any make-up contributions you missed from the first day of the COBRA coverage.

- If COBRA is elected, the coverage previously in effect will generally be continued.
- Coverage will be effective as of the date of the qualifying life event, unless you waive COBRA coverage and subsequently revoke your waiver within the 60-day election period. In that case, your election coverage begins on the date you revoke your waiver.
- You may change coverage during annual enrollment or if you experience a qualifying life event, as described in the "About Your Benefits" section.
- You may enroll any newly eligible spouse or child under the usual rules.

## Cost of Participation

COBRA participants must pay monthly premiums for their coverage:

- For medical and dental coverage, premiums are based on the full group rate per covered person set at the beginning of the year, plus 2% to cover administrative costs.

## Notification

If your dependents lose coverage due to divorce, legal separation, or loss of dependent status, you (or a family member) must notify the Benefit Plans Office within 60 days of the event so that COBRA can be offered and your election rights can be mailed to you. Also, to extend coverage beyond 18 months because of disability, notice of the Social Security Administration's determination must be provided within 60 days after you receive that determination and before the end of the initial 18-month period.

## When COBRA Ends

COBRA coverage will end before the maximum continuation period if:

- a person who was covered under COBRA becomes covered under another group health plan not offered by the Company (providing the other plan does not have pre-existing condition limitations affecting the covered person; if the other plan has such limitations, COBRA coverage will end when those limitations expire)
- you or your eligible dependent becomes entitled to Medicare after you elect COBRA
- the first required premium is not paid within 45 days, or any subsequent premium is not paid within 30 days of the due date  
*or*
- the Company's group health plans are terminated.



# Your Rights Under ERISA

As a participant in any of the Company's benefit plans described in this handbook, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive information about your plan and benefits.
- Examine, without charge, at the plan administrator's office, and at other specified worksites, all plan documents - including pertinent insurance contracts, trust agreements, collective bargaining agreements, annual reports, and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain copies of all plan documents and other plan information, including insurance contracts and collective bargaining agreements, and copies of the latest annual report, and updated summary plan description, by writing to the plan administrator. The plan administrator may make a reasonable charge for copies.
- Receive a summary annual report of the plan's financial activities. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants, and beneficiaries. No one, including your employer, your union, or any other person, may fire you, or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

# Your Rights Under ERISA (cont'd.)

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

